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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras

Summary

In the present report, submitted pursuant to Council resolution 24/6, the Special Rapporteur provides a brief account of his activities since he took office in August 2014.

The main focus of the report is on the work of the mandate of the Special Rapporteur on the right to health, focusing on the right to health framework, and the development of the contours and content of the right to health. He then reflects on how he sees the way forward, based on the current context, challenges and opportunities for the full realisation of the right to health.

The Special Rapporteur provides his conclusions and observations.

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I. Introduction

1. The present report is the first submitted to the Council by the newly appointed Special Rapporteur, Dainius Pūras, and is the twenty-fourth thematic report submitted by the mandate holder on the enjoyment of the right to health since the establishment of the mandate in 2003. The report is submitted pursuant to Council resolution 24/6.

2. The Special Rapporteur provides a brief account of his activities since his appointment, including communications, country visits and cooperation with the United Nations system and other key stakeholders.

3. The Special Rapporteur provides an overview of the work of the mandate since 2003, focusing on the right to health framework, and the development of the contours and content of the right to health. He then reflects on how he sees the way forward, based on the current context, challenges and opportunities for the full realization of the right to health. He lays out the main themes as priorities for the coming years. In the final chapter, the Special Rapporteur provides his conclusions and observations.

II. Activities during the reporting period

A. Communications transmitted to States

4. During the reporting period, between 1 March 2014 and 28 February 2015, the Special Rapporteurs sent 72 communications to 39 States. At the time of writing, 36 responses had been received, indicating a 52 per cent response rate.

B. Country visits

5. During the reporting period, the Special Rapporteur visited Malaysia from 19 November to 2 December 2014. He would like to thank the Government for extending this invitation and facilitating the visit. A separate report on this visit has been submitted as addenda 1 to the present report (A/HRC/29/33/Add.1). Comments by the Government thereon have been submitted (A/HRC/29/33/Add.2).

6. The Special Rapporteur would like to thank the Government of Algeria for having extended an invitation to conduct a country visit, and hopes this visit will take place in the coming months.

C. Cooperation with the United Nations system and intergovernmental organizations

7. The Special Rapporteur participated in sessions, meetings and events linked to the discharge of his mandate, including the induction course for new mandate holders (3–5 September 2014); the 21st Annual Meeting of Special Procedures of the Human Rights Council (29 September–3 October 2014); and the sixty-ninth session of the General Assembly (27–30 October 2014).

8. In addition, on 18 September 2014, the Special Rapporteur participated as panellist in the high-level launch of the technical guidance on the application of a human rights-based approach to reduce and eliminate preventable mortality and morbidity of children under 5 years of age, which took place in Geneva.

9. From 9 to 11 December 2014, the Special Rapporteur was invited to attend the Programme Coordinating Board meeting of the Joint United Nations Programme on HIV/AIDS, which took place in Geneva. In the context of that meeting, the Special Rapporteur participated in various meetings and events, including on harm reduction issues.

10. On 16 and 17 October 2014, the Special Rapporteur was invited to participate in the symposium on the rights of persons with psychosocial disabilities, which was organized by OHCHR Regional Office for Europe in Brussels.

11. From 18 to 20 February, the Special Rapporteur participated as panellist at the 2015 Social Forum, which took place in Geneva and focused on access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including best practices in this regard.

D. Cooperation with non-governmental organizations

12. On 3 October 2014, the Special Rapporteur participated in an event on "Autism and Human Rights throughout the Life Course", organized by the NGO Forum for Health and which took place in Geneva.

III. Overview of the work of the mandate (2003–2014)

13. The mandate of the Special Rapporteur on the right to of everyone to the enjoyment of the highest attainable standard of physical and mental health was originally established by the Commission on Human Rights in April 2002 in resolution 2002/31, and renewed in 2005 in resolution 2005/24. Subsequent to the replacement of the Commission with the Human Rights Council in June 2006, the mandate was endorsed and extended by the Council through resolutions 6/29, 15/22 and 24/6.

14. The new Special Rapporteur was appointed in August 2014 and feels privileged to have been given the opportunity to assess the realization of the right to health in the coming years. He will make use of his voice and of all tools available to discharge his mandate and contribute to the full enjoyment of the right to health by all. In his first report to the Human Rights Council, the Special Rapporteur focuses on the work of the mandate, including challenges and opportunities, and on how he sees the way forward in the discharge of his functions.

15. During the first years of the existence of the mandate, the first Special Rapporteur, in collaboration with the Committee on Economic, Social and Cultural Rights, the World Health Organization (WHO), civil society and the academic sector, developed a framework for analysing the right to health with a view to making it easier to understand and apply to health-related policies, programmes and projects in practice.

16. The analytical framework that was developed consists of several key elements and has a general and inclusive application to all aspects of the right to health, including the underlying and social determinants of health and timely and appropriate medical care. The framework is intended to address the crucial question of what human rights in general, and what the right to health in particular, bring to policymaking process (see E/CN.4/2003/58, para. 9). That question remains valid today and will continue guiding the work of the Special Rapporteur.

17. The first mandate holder identified three primary objectives for the mandate: to promote — and encourage others to promote — the right to health as a fundamental human right; to clarify the contours and content of the right to health; and to identify good practices for the operationalization of the right to health at the community, national and

international levels (see E/CN.4/2003/58, para. 9). The then Special Rapporteur explored those three objectives by way of two interrelated themes: the right to health in relation to poverty, focusing on health-related Millennium Development Goals; and the right to health and the determinants of discrimination and stigma.

18. Throughout his tenure, the former Special Rapporteur Paul Hunt distinguished between judicially oriented and policy-oriented processes. Although the two approaches are closely related and mutually reinforcing, the former aims to promote and protect the right to health via the drawing up of rules and principles derived from case law, building up general guidance from the lessons learned via the resolution of particular disputes. Judicial and quasi-judicial forms of accountability exemplify this approach. The former Rapporteur also emphasized that the policy approach is not a soft option, on the contrary, it places a legal obligation on policymakers to ensure that a health system includes comprehensive health plans encompassing the public and private sectors, outreach programmes for the disadvantaged and numerous other features demanded by the right to health. The policy approach is not without accountability: it requires that policymakers are subject to judicial and non-judicial forms of review.

19. The work of the mandate has addressed the challenges and opportunities related to progressive realization of the right to health and those obligations that have immediate effect. With regard to resource constraints and progressive realization, international human rights law recognizes that the realization of the right to health is subject to progressive realization based on resource availability. That is why a higher standard is required of a developed State today than is required of a developing State. However, all States are obliged to realize progressively the right to the highest attainable standard of health. In order to measure progress, indicators and benchmarks need to be identified, and the work of the first mandate holder in that regard continues to be very useful (see A/58/427 and E/CN.4/2006/58).

20. Previous mandate holders have given details of the challenges and opportunities that arise from the right to available, accessible, acceptable and good-quality health-care services. In that regard, health-care systems are at the heart of the right to health and act as a fundamental building block of sustainable development, poverty reduction and economic prosperity (A/HRC/7/11, para. 12). The principles embodied in the Alma-Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986) remain relevant today.

21. The work of the mandate has also addressed the challenges for States in realizing their obligations to ensure that adequate funds are available for health in national budgets, to safeguard an equitable allocation of health resources and to enhance international cooperation to promote sustainable international funding for health (see A/67/302).

22. The work of the Special Rapporteur's predecessors has highlighted that one of most important obligations of immediate effect related to right to health is the duty to avoid discrimination.[1] This means that, even in the presence of resource constraints, that obligation should not be subject to progressive realization. Discrimination and stigma are considered as social determinants in the enjoyment of the right to health, as social inequalities and exclusion shape health outcomes and contribute to increasing the burden of disease borne by marginalized groups. In addition, some health conditions, such as mental health or HIV/AIDS, may involve exposure to compounded forms of discrimination and reinforce existing inequalities (E/CN.4/2003/58, para. 59).

[1] See Committee on Economic Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 43.

23. The work of previous mandate holders has underlined the need to respect, protect and fulfil the enjoyment of right to health and other related rights of those groups who appear to be in vulnerable situations and face discrimination in general, including in accessing health-care services.

24. Previous work on the issue of sexual and reproductive health and rights, including on maternal mortality, has shown that human rights when applied to public health policies can save lives by ensuring that health policies are equitable, inclusive, non-discriminatory, participatory and evidence-based (A/61/338, para. 29). Most of pregnancy-related deaths and many of the causes of under-5 mortality are avoidable. Those most at risk are groups living in poverty, groups in rural areas and women from ethnic and religious minorities or indigenous communities. Women and children must be placed at the centre of an integrated approach to sexual and reproductive health and their rights must be fully recognized.

25. Moreover, the work of the mandate has focused on the serious detrimental impact that the criminalization of identities, behaviours and health status can have on the full enjoyment of the right to health. Criminalization and restrictive laws are ineffective as public health interventions and fuel underreporting of health indicators. For instance, the work done has shown that legal restrictions on access to abortion services, comprehensive sexual and reproductive education and information, and contraception and family planning methods can have a serious detrimental impact on the enjoyment of the right to health. Evidence shows that this includes a negative impact not only on access to goods, services and information, but also on the enjoyment of fundamental freedoms and entitlements, and on the dignity and autonomy of individuals, in particular women (see A/66/254).

26. Previous mandate holders have also looked into the negative impact of the criminalization of consensual same-sex conduct, of sexual orientation and gender identity, of sex work and of HIV transmission (see A/HRC/14/20). Such work has shown that punitive policies and criminalization are not effective and act as a barrier to access health services, fuel social stigma and exclusion and lead to poor health outcomes.

27. On the issue of drug policy, the work of the Special Rapporteur's predecessors has shown that the current international system's punitive regime, which focuses on creating a drug-free world, has failed mostly owing to ignorance of the realities surrounding drug use and dependence (see A/65/255). There is a need for a shift in the current drug control regime away from substance-oriented policies and an increased focus on human rights. Evidence has shown that the criminalization of certain behaviours leads to a reluctance to seek help, including health-related services, and this should be a concern to the authorities. Pursuing overly punitive approaches has resulted in more health-related harms than those the authorities seek to prevent.

28. The important issue of access to medicines has also been part of the work of the mandate. Medical care in the event of sickness and the prevention, treatment and control of diseases depend to a great extent on timely access to quality medicines. Despite progress made, an estimated 2 billion people still lack access to essential medicines. There remains an intrinsic link between poverty and the realization of the right to health, where developing nations have the greatest need and the least access to medicines. Previous mandate holders, including Anand Grover, have given details of the different dimensions of the issues, such as: the role and responsibilities of pharmaceutical companies; the impact of intellectual property laws and free-trade agreements; and the implications and elements of a right-to-health approach to access to medicines (see A/63/263, A/HRC/17/43 and A/HRC/23/42).

29. During the past 12 years, the work of the mandate has also paid special attention to two other key elements of the analytical right-to-health framework: monitoring and accountability. Without monitoring and accountability, all human rights norms and obligations are likely to become empty promises. Accountability in respect of the right to

health and a health system is often quite weak (see A/63/263). Judicial accountability has been highlighted by the work of the mandate (see A/69/299) but other forms of accountability, such as health impact assessments, have also been addressed, including during country visits (Romania, Sweden and Uganda).

30. Other thematic reports have explored the enjoyment of the right to health and the underlying determinants, including water and sanitation, occupational health, the right to health in conflict, unhealthy foods, and the right to health of migrants, older persons and persons with psychosocial disabilities (including the key issue of informed consent).

31. The Special Rapporteur concurs with his predecessors that a comprehensive right-to-health approach is necessary, which includes decriminalization of sexual orientation and gender identities, certain behaviours and health status, as well as the establishment of conducive legal and administrative frameworks with emphasis on human rights education, meaningful participation and empowerment of the groups targeted, and serious efforts to reduce stigma and discrimination in society as a whole.

IV. The way forward: context, challenges and opportunities

32. In the words of Jonathan Mann "the human rights framework provides a more useful approach for analysing and responding to modern public health challenges than any framework thus far available with the biomedical tradition".[2] The Special Rapporteur will address the most important issues related to the discharge of his mandate with that in mind.

33. The right of everyone to physical and mental health can only be realized through concerted and sustained efforts, and shared responsibility by all stakeholders at national, regional and universal levels. It requires an unequivocal commitment to the realization of universal human rights principles as enshrined in the Universal Declaration on Human Rights and human rights law and standards.

34. Building on the work of his predecessors, the Special Rapporteur will advocate for the application of the right to health framework to strengthen health systems, emphasizing the need to place the well-being of individuals and communities at the centre of health policies. He will look at processes within health systems — at how things are done and the actors involved — with particular attention devoted to access to information, participation and accountability mechanisms in place (see A/HRC/7/11, paras. 38–64).

35. The Special Rapporteur will continue applying a gender perspective in his work, with a special focus on sexual and reproductive health and rights as an integral part of the right to health. He will apply a life-cycle approach to his work, paying special attention to the needs of the children and adolescents in the realization of the right to health, and the needs of other groups in vulnerable situations, including persons with disabilities. He will continue paying attention to the issue of access to medicines, including access to essential and controlled medicines, and its human rights dimensions.

36. In the current context of the shaping of the Sustainable Development Goals, the realization of the right to health is extremely relevant, both as precondition for, and as an outcome of, a successful process of achieving the Sustainable Development Goals and their main elements.

[2] Mann, "Health and human rights. Protecting human rights is essential for promoting health", *British Medical Journal*, No. 312 (1996), pp. 924–925.

A. The policy approach to the right to health

37. There are different and equally relevant ways to apply a human rights-based approach for improving the health of individuals and populations, and to promote the right to health in everyday practices. One such approach is looking at normative frameworks, including at the role of legislation and litigation through courts, which inter alia underlines the importance of the justiciability of the right to health.

38. The approach that the Special Rapporteur will prioritize is what he calls the "policy approach", which focuses on health and health-related policies, including the analysis of processes and outcomes of policies as they are formulated and implemented. It will consider whether or not these policies are based on human rights principles and modern public health approaches, including solid scientific evidence.

39. Departure from universal human rights principles and standards, as enshrined in the Universal Declaration, and from evidence provided by the modern public health approach is a major obstacle for effective realization of the right to health. The Special Rapporteur will use the right to health framework to identify good practices in the operationalization of modern principles of health promotion. He will underline the possible synergies between the human rights and the modern public health approaches for the realization of the right to health worldwide.

40. One the objectives of the Special Rapporteur will be to examine the "implementation gap". The human rights-based approach can be very effective in implementing health policies and practices. However, while the fundamental principles and the main processes and mechanisms of the right to health are well identified, there still remains a significant gap between the formulation of health policies and their effective implementation in everyday practice. While the formulation of health policies may be satisfactory from the perspective of the right to health, their effective implementation remains a significant challenge.

41. All too often, the failure to put basic principles into practice is not linked to financial obstacles, but is mostly owing to prevailing attitudes among stakeholders that are not in line with human rights and public health principles. The Special Rapporteur will focus on the "implementation gap" but he will continue to underline, interpret and link the fundamental universal human rights principles and standards with the everyday practice of effective investment in individual and societal health.

42. Despite the work of many who have convincingly highlighted the need and benefits to adhere to universal human rights principles, there continues to be a tendency to apply and justify a narrow and selective approach to human rights, including to the right to health. That tendency has been accentuated during the last decade and questions the very essence of universal human rights principles and standards.

43. For example, such a retrogressive tendency has been observed in the area of sexual and reproductive health and rights, and with regard to discrimination against groups in vulnerable situations, including children, documented and undocumented migrants, persons with disabilities and lesbian, gay, bisexual and transgender persons. In his reports and through his other activities, the Special Rapporteur will highlight the need and importance of applying the principle of the interdependence and indivisibility of human rights, and will underline how essential this is for the full realization of the right to health.

44. The Special Rapporteur is concerned that this tendency to take a selective approach to human rights has its most detrimental effects on those groups of population which face de jure or de facto discrimination. These groups suffer from social exclusion, stigmatization and humiliation, which has a negative impact to their health status. They are often deprived of access to health support and the care services they need, and of meaningful participation

in processes that affect them. These are the groups in most need of quality and human rights-friendly health-care services precisely because of their situation.

45. This departure from universal human rights principles and this selective approach, ignoring or not adequately addressing one or more rights of a group of the population, reinforces cycles of poverty, inequalities, social exclusion, discrimination and violence, and in the longer run has a negative impact on the health and development of society in general.

46. There are good health practices worldwide that emerge when culturally and socially appropriate programmes are used, involving and empowering individuals, families and communities. These practices challenge traditional barriers between health, education, social welfare and other sectors. For example, effective programmes can be developed to enable community support for preventing violence, particularly violence against women and domestic violence. Community-based initiatives and neighbourhood prevention activities can also be designed to provide education for first-time parents, focusing on child-parent relationships. Support to family planning activities can be put in place to prevent early or unwanted pregnancies through the provision of comprehensive sexuality education and information, and by providing access to a varied range of contraception methods.

47. The cooperation between sectors can also be beneficial to facilitate access to preschool education, especially for children of families at risk, and enable community readiness to accept and integrate children and adults with disabilities into all of the everyday life of the community. This approach can also offer opportunities for adolescents and youth at risk to find alternatives to youth violence by engaging them in community programmes that support recreation centres for older persons, thus contributing to the reinforcement of intergenerational links and improving the quality of human relationships in general.

48. The "policy approach", if implemented effectively, creates valuable opportunities for social innovations through the empowerment of citizens, families, communities and societies at large. By using modern concepts of health promotion and public health, this approach can also facilitate the meaningful participation of all stakeholders and reinforce the protective factors and resilience of individuals and communities.

B. Right to health policies: power asymmetries, unbalanced approaches and other challenges

49. The implementation of evidence-based medicine and public health science is often hindered by the departure from such evidence, resulting in unbalanced and selective policies and practices that hamper the full realization of human rights, including the right to health. One way to analyse the challenges to and opportunities for the effective realization of right to health is to focus on the need to balance the important elements of the right and to prevent tendencies and incentives which lead to power asymmetries and unfair policies and practices.

50. The imbalances in health-related policies and practices are often a result of power struggles and an outcome and sign of a lack of transparency, accountability and political will to follow established principles and standards. Such imbalances emerge often as a consequence of a departure from a holistic approach to human rights. This is reinforced by power asymmetries between stakeholders and interest groups within and outside of health sector. These selective policies and practices tend to lead to ineffective health policies and ineffective, even harmful, health-care practices and to violations of human rights.

51. The Special Rapporteur is concerned about instances of unbalanced policies and practices which seriously undermine the full enjoyment of the right to health. Those imbalances can lead to an artificial hierarchy and a selective approach to human rights prioritizing one group of rights over another, or can set different human rights standards for different groups of the population. Some imbalances and power asymmetries are present within the different elements of health systems; for example, primary care often fails to compete for budget allocations with specialized medicine. These imbalances have also historically led to disparities in investing in physical and mental health.

1. No hierarchy within human rights

52. Lessons should be learned from past and present experiences, which demonstrate that any hierarchy among human rights, a prioritizing of one right or one group of rights over another, leads to detrimental outcomes and systemic violations of human rights. Selective approaches deprive certain groups of basic rights and undermine the meaningful participation and empowerment of all stakeholders. Such participation and empowerment are crucial preconditions for positive public policy outcomes, which are based on the particular attention given to those in vulnerable situations.

53. Many examples have been presented by the health and human rights movement of economic, social and cultural rights being neglected since they were perceived as not requiring immediate action based on erroneous interpretations of the fact that they were subject to progressive realization. That tendency to undermine importance of economic, social and cultural rights has led, and continues to lead, to a detrimental combination of poverty, inequalities and disempowerment of large groups of population, who will consequently suffer from poor health status and barriers to accessing health-care services.

54. The right to health approach, as a part of human rights-based approach, has emerged during recent decades as a powerful tool to reinforce the global goal of improving the health and well-being of populations. However, it can also be used to monitor and prevent those underlying health conditions and tendencies within health-care systems which may lead to violations of human rights and to a negative impact on the health of individuals and societies.

55. In this regard, the Special Rapporteur will continue highlighting the need to reduce poverty and inequalities, including those within and between regions and countries. He will do so by analysing the root causes of the gap between opportunities and reality, between evidence, policies and practices and between obligations of duty bearers and effective implementation.

56. A recent example of the detrimental effect of inequalities has been the Ebola epidemic in countries of Western Africa with weak health-care systems which were not able to adequately respond. One of the lessons learned from that and other epidemics is the importance of social medicine which, since the nineteenth century has highlighted that many diseases and epidemics are social diseases in their origin; therefore, primary prevention should properly address the social determinants of health and the context in which epidemics emerge.

57. The Ebola crisis has provided meaningful lessons with regard to many elements of the right to health. It has questioned our preparedness for emergencies at national, regional and global levels. It has raised important issues, such as access to information, trust in public authorities and safety of medical personnel, and it has reminded us of the importance of upholding the human rights of the affected populations in the context of public safety concerns. The Ebola crisis has once again raised issue of the responsibility and social accountability of key actors, including pharmaceutical companies, and the need for strong public leadership in addressing global health challenges.

58. Another example of an unbalanced approach to human rights is when the full realization of the right to health is hindered by undue restrictions in the enjoyment of civil and political rights. That approach can lead to a failure in the implementation of the principles of participation and empowerment and it undermines the crucial role that civil society can play in promoting societal health and well-being.

59. There is no hierarchy among human rights, and any attempt to restrict or undermine, intentionally or unintentionally, any of the basic human rights can have a harmful impact on individual and societal health and well-being. That is why the best way of "vaccinating" health-care systems and policy decisions against a departure from agreed principles and standards is to systematically apply a human rights approach in full accordance with universal principles enshrined in the Universal Declaration of Human Rights and human rights conventions and treaties.

2. Balancing the key elements in the health-care system

60. All key elements of health-care systems must be balanced. That includes the relationships between the curative and preventive aspects of health care, so that power asymmetries do not weaken primary care and preventive medicine. The modern public-health approach should be strengthened and a right balance between all elements of the health-care system should be ensured so that the implementation of health policies is not dominated by vertical "disease-based" programmes and specialized health-care services.

61. In addition, the role of the health sector and that of other sectors in improving the health of individuals and populations must also be balanced. A modern understanding of the effective realization of right to health requires a "health in all policies" approach. To fully achieve goals, such as to reduce infant or under-5 mortality, improve mental health, reduce the burden of non-communicable diseases or promote the health of older persons, all sectors and all branches responsible for public policies need to be involved.

62. This does not mean that role of health sector should be restricted to specialized health care. On the contrary, the scenario of ministries of health preoccupied mainly with meeting the need of specialized health-care services is an outdated one. The role of the health sector is becoming increasingly important in areas such as health promotion, prevention of health problems and protection of human rights, especially within health-care services, with particular attention given to the situation of marginalized groups. In the promotion of a "health in all policies" approach, the health sector should take the lead and share responsibility for societal health with other sectors.

63. With all this in mind, the Special Rapporteur is considering the analysis of the following themes as some of his priorities.

V. Themes as priorities

A. Global health in the post-2015 agenda

64. The transition from Millennium Development Goals to Sustainable Development Goals is a unique opportunity to rethink achievements and assess the remaining challenges affecting the right to health and well-being of individuals and societies. In the decade between 2000 and 2010, an estimated 3.3 million deaths from malaria were averted and 22 million lives were saved in the fight against tuberculosis. Access to retroviral therapy for

HIV-infected people has saved 6.6 million lives since 1995. At the same time, access to child and maternal health care has improved steadily.[5]

65. Since the end of nineteenth century, science and the practice of medicine and public health have created enormous opportunities for preventing premature mortality and improving the health and well-being of individuals and societies. Many scientific discoveries have been successfully put into practice, resulting in an overall increase of life expectancy, a reduction in maternal and child mortality, a successful combat against many infectious diseases and a general improvement of the quality of life of the world's population.

66. However, current rates of preventable deaths among newborns, children under 5 and adults are still unacceptably high. Universal health-care coverage is still a dream for many. The realization of the right to health is impeded by many factors, and most of them are related to inequalities, and selective approaches to human rights principles and existing scientific evidence. This can and must be addressed with the strong commitment by States and concerted efforts by all stakeholders.

67. In the context of the post-2015 agenda, the right to health framework can be a useful and powerful analytical and operational tool for the transition to the Sustainable Development Goals. And the Sustainable Development Goals can be instrumental for the effective and holistic realization of the right to health, if human rights are effectively incorporated in their conceptualization.

B. The right to health and public policy

68. Primary care is to be strengthened in the twenty-first century as the crucial cornerstone of modern medicine and public health. The Alma-Ata Declaration and Ottawa Charter for Health Promotion should be reaffirmed and the root causes of the relative failure to achieve commitments to "health for all by 2000" should be sought.

69. Without a well-established infrastructure of primary health care, all achievements of modern science and the practice of medicine might be compromised and could be misused. When health policy chooses to prioritize specialized services, the latter tend to function without the necessary ethical and human rights safeguards, leading to barriers in access to services for people and groups who have more health needs or to the ineffective use of those services, or to both.

70. The Special Rapporteur is concerned that primary care and the modern public health approach often lose the battle for resources to the biomedical model and vertical programmes of treatment of diseases through specialized health care. When resources are allocated to specialized health care, that may reinforce power asymmetries and funding imbalances, which often favour powerful groups representing vested interests in the health sector and industry. States, when meeting their obligation to protect, respect and fulfil the enjoyment of the right to health, should be aware of, and be willing and able to address, such power asymmetries. They should also provide mechanisms for independent monitoring, as such mechanisms are essential tools in ensuring accountability.

71. If that does not happen, power asymmetries and imbalances may lead to scenarios where (a) preference in allocating budgets is given to expensive biomedical technologies

[5] *Millennium Development Report 2014*, quoted in "The road to dignity by 2030: ending poverty, transforming all lives and protecting the planet", synthesis report of the Secretary-General on the post-2015 sustainable development agenda (A/69/700), para. 17.

which are not necessarily used in an ethical and cost-effective way; (b) there are increased incentives for corruptive practices when expensive specialized health-care interventions in public sector do not serve those in most need; (c) the filters (tiers) in health-care systems do not properly function, and mild cases flow into specialized care, placing the entire health-care system at risk of poor management of the principles of medical ethics and health economics. That has negative impact on the full realization of right to health and generates negative public health outcomes.

72. The sustainable implementation of a modern public health approach is not only in line with human rights, but is also a powerful way to develop and strengthen social justice and social cohesion. In that regard, the importance of universal health coverage cannot be overestimated. Since the International Conference on Primary Health Care, there have been many achievements, but also failures. Universal coverage is a central component of healthy public policies and its global achievement should be seen as one of the main goals for the post-2015 agenda. However, the Special Rapporteur thinks that a broader holistic approach is needed so that none, in particular those in vulnerable situations and in most need of health care, are not excluded neither de jure nor de facto from access to quality services.

73. All international and national actors should be mobilized to reaffirm and revitalize the decisions of the historic International Conference on Primary Health Care and International Conference on Health Promotion. The full enjoyment of the right to health can only be operationalized through human rights-friendly and culturally relevant health promotion policies that empower people to increase control over their lives and improve their health and well-being.

C. Mental health and emotional well-being

74. The historical divide, both in policies and practices, between mental and physical health has unfortunately resulted in political, professional and geographical isolation, marginalization and stigmatization of mental health care.

75. The modern public mental health approach, which emerged in the global scene in the end of twentieth century with a critical mass of new evidence on the importance of mental health and the effectiveness of integrated approaches, still faces enormous challenges. It is regrettable that, in many countries and regions of the world, modern mental health care is still not available. Moreover, in countries which can afford to give resources to mental-health services, those resources are often used to support segregated psychiatric institutions where stigmatizing and human rights-unfriendly services are provided.

76. The Special Rapporteur would like to highlight two key messages of the modern public mental-health approach. Firstly, there is no health without mental health. Secondly, good mental health means much more than absence of a mental impairment.

77. The modern understanding of mental health includes good emotional and social well-being, healthy non-violent relations between individuals and groups, with mutual trust of, tolerance of and respect for the dignity of every person. In that regard, promoting good mental health should be a cross-cutting priority relevant to the sustainable development agenda, as it is of concern to many of its elements, including the protection of dignity and people in order to ensure healthy lives and strong inclusive economies; promote safe and peaceful societies and strong institutions; and catalyse global solidarity for sustainable development (see A/69/700).

78. By investing in the good mental health of children and youth, a substantial contribution is made not only to the sustainable development of our economies, for which good emotional and cognitive abilities are needed, but also the root causes of intolerance and social exclusion are addressed and healthy and cohesive societies promoted.

79. It is estimated that the burden of mental-health problems and mental disabilities constitutes 14 per cent of general burden of disease.[4] However, compared with physical health, mental health is given inadequately low priority and insufficient human and financial resources.

80. The end of twentieth century brought two main messages to the international community. The first message was about the centrality of mental health in the modern health policies, based on the high burden of mental-health problems and mental disorders. The second message was that, contrary to the previous understanding, effective measures are possible if outdated traditions are abandoned and the modern public health approach is applied. In the twenty-first century there is no place for psychiatric institutions based on stigma and segregation, and there is a need, in words of G.H. Brundtland "to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason".[5]

81. However, after more than a decade since the publication of the landmark *World Health Report 2001*, mental health remains hostage to outdated attitudes and inadequate services. Studies show that, in many instances, there is either no access to mental health services at all, or those services are stigmatizing and violate human rights.[6]

82. One of the significant obstacles to the implementation of modern public mental-health principles is a lack of political will, including on global health agenda, to recognize the centrality of mental health in the full realization of the right to health and to implement the principle of parity between physical and mental health. The Special Rapporteur is concerned that, despite clear evidence of the increasingly heavy burden of mental ill-health, many important stakeholders continue to marginalize this field of health.

83. Mental health deserves much more attention and must be effectively mainstreamed within the Sustainable Development Goals through the goals and benchmarks related to health and sustainable development. The high number of suicides and suicide attempts are an indicator that the mental health of individuals and population needs to be addressed very seriously.[7] Concerted and effective measures need to be applied to substantively address this challenge and reduce the numbers of suicides, which have in many countries reached epidemic rates. The Special Rapporteur will further analyse the relevance of human rights in addressing suicide and other mental health issues as a public health challenge.

84. In some regions, resources allocated to mental health care are used ineffectively and predominantly for maintaining large segregated psychiatric long-term care institutions and separate psychiatric hospitals. In such institutions, psychotropic medications are too often overprescribed, including as a measure of chemical restraint or even as a punishment. That is an example of an imbalance: when resources are used for biomedical interventions and institutionalization and not for the development of psychosocial interventions through community-based services meeting more closely the individual needs of people. Such imbalances feed ineffective systems, reinforce stigma and social exclusion and lead to systemic violations of human rights, sometimes amounting to torture or ill-treatment.

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[4] WHO estimates available from www.who.int/mental_health/mhgap/en/.

[5] *World Health Report 2001 - Mental Health: New Understanding, New Hope* (Geneva, Switzerland, 2001), p. x.

[6] Saraceno B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D., Chris Underhill, Ch., "Barriers to improvement of mental health services in low-income and middle-income countries", *The Lancet*, vol. 370 (2007), pp. 1164–1174.

[7] See WHO, "Preventing suicide — a global imperative" (2014).

85. This, once again, reflects power asymmetries between interest groups behind different forms of services and interventions, and a lack of transparency, monitoring and accountability in mental health-care systems. WHO recommendations are very clear about the five obligatory components of community-based care for persons with severe psychosocial disabilities, which comprise access to psychotropic medications, psychotherapy, psychosocial rehabilitation, vocational rehabilitation and employment and supported housing. However, in many countries, a number of those components are not being implemented.[8]

D. The life-cycle approach to the right to health

86. There is overwhelming evidence that many children die too young from preventable causes and/or suffer high levels of violence and insecurity. Consequently, the health status, quality of life and well-being of many individuals, groups and entire societies worldwide remain unacceptably low. The Special Rapporteur believes that the life-cycle approach can be used as one method to identify the critical elements of the challenges and opportunities for the reduction of preventable deaths and the improvement of health indicators, well-being and quality of life.

87. The Special Rapporteur is planning to address right-to-health challenges using, among other methods, a life-cycle approach. Such an approach helps identify critical elements of challenges and opportunities for full realization of the right to health. It is during some important stages of the life course that the right to health needs to be particularly protected, since during those stages there is a greater risk of violations of human rights, including the right to health. On the other hand, interventions during those critical stages of life open up new opportunities and offer new health protective factors. The life-cycle approach can help in the prevention of chronic diseases in adult life through the effective protection of children from early childhood adversities.

88. In line with the life-cycle approach, the Special Rapporteur will dedicate his next thematic report to the challenges to, opportunities for and best practices in promoting the right to health in early childhood. He will analyse two interdependent and indivisible rights directly related to the right to health: the right to survival and the right to development during first five years of life.

89. The right to survival relates to the prevention of infant and under-5 mortality. Despite many achievements in the field of medicine, 6 million children under 5 die every year in the world. Those children do not die of unknown or incurable diseases or illnesses: they die because of the conditions in which they and their parents live and poor governance and accountability.

90. The launch of the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31) in 2014 is a serious attempt to put an end to the unacceptable epidemics of preventable deaths of infants. The human rights-based approach is critically important in that regard since child mortality is intimately linked with human rights of women and the widespread discrimination against vulnerable groups of population.

91. The right to holistic development is another equally important element of the right to health of children. Children need to be protected through the promotion and protection of their economic, social and cultural rights. Furthermore, from the moment of birth, children

[8] See WHO, *World Health Report 2001*.

should also be considered as citizens entitled to all rights, including civil rights and freedoms. Their right to health should be promoted not only through the prevention of child mortality and morbidity but also through the protection of children's right to holistic development.

92. The life-cycle approach will be also be used in addressing the right of adolescents and youth to health; the role of family and parenting; mental-health issues and ways to prevent violence as a public health problem; and important issues around healthy ageing.

E. The right to health of persons with disabilities

93. One of priorities of the Special Rapporteur will be to look into the role of the health sector and health professionals in the implementation of ambitious goals raised by the Convention of the Rights of Persons with Disabilities. He hopes to address that role in close cooperation with the Special Rapporteur on the rights of persons with disabilities, and other mandate holders and United Nations mechanisms.

94. The human rights standards set forth by the Convention present a good opportunity to rethink the historical legacy of previous models and to move away from those health-care practices which are against human rights and the modern public health approach. There is a unique and historic opportunity to end the legacy of the overuse and misuse of the biomedical model.

95. All persons with disabilities have a right to health, including to quality health-care services. In that regard, persons with disabilities should not be discriminated against and should enjoy that right in their communities as persons without disabilities do. The Special Rapporteur is concerned that all too often children and adults with different forms of disabilities are deprived of the full realization to the right to health. He will address that serious issue, with a particular focus on the rights of persons with psychosocial and intellectual disabilities.

96. The Convention is challenging traditional practices of psychiatry, both at the scientific and clinical-practice levels. In that regard, there is a serious need to discuss issues related to human rights in psychiatry and to develop mechanisms for the effective protection of the rights of persons with mental disabilities.

97. The history of psychiatry demonstrates that the good intentions of service providers can turn into violations of the human rights of service users. The traditional arguments that restrict the human rights of persons diagnosed with psychosocial and intellectual disabilities, which are based on the medical necessity to provide those persons with necessary treatment and/or to protect his/her or public safety, are now seriously being questioned as they are not in conformity with the Convention.

98. The Special Rapporteur believes that a serious multi-stakeholder dialogue about the future models and practices of psychiatry is needed to address the situation in many countries where exceptions, allowing the restriction of the human rights of service users, sadly turn into rules, and persons with psychosocial and intellectual disabilities suffer from systemic or ad hoc violations of their rights.

99. A large number of persons with psychosocial disabilities are deprived of their liberty in closed institutions and are deprived of legal capacity on the grounds of their medical diagnosis. This is an illustration of the misuse of the science and practice of medicine, and it highlights the need to re-evaluate the role of the current biomedical model as dominating the mental-health scene. Alternative models, with a strong focus on human rights, experiences and relationships and which take social contexts into account, should be considered to advance current research and practice.

100. The issue of shared responsibility is as a crucial one. Representatives of professional health-care groups, including psychiatry, should agree that it is in the interest of all to de-monopolize the decision-making process and to develop mechanisms for sharing competences and responsibilities between actors, including providers and users of services, policymakers and civil society.

F. Violence as a major obstacle for the realization of the right to health

101. Protection from all forms of violence is considered by the Special Rapporteur as a cross-cutting issue present in all key elements of the realization of the right to health. As the United Nations High Commissioner for Human Rights has recently underlined, violence and human rights violations are often rooted in the deprivation and discrimination of individuals and communities. Such violations are not generated spontaneously but "result from policy choices which limit freedoms and participation, and create obstacles to the fair sharing of resources and opportunities".[9] Violence needs to be addressed in a comprehensive and proactive way, not only as a cause of serious violations of human rights, but also as a consequence of a lack of political will to effectively invest in human rights, including the right to health.

102. It was not until the end of the twentieth century that the close link between violence and health began to be sufficiently understood. Interestingly, as health and human rights came closer, a similar tendency could be observed by the turn of century when violence was finally seen as a public health concern. In 1996, the World Health Assembly declared violence as "a leading worldwide public health problem".[10] Since then, the burden of violence has been documented and the effectiveness of programmes, with particular attention devoted to women and children and community-based initiatives, has been assessed.

103. Evidence has shown that, when violence is addressed proactively as a public health issue, there are more opportunities to break the cycle of violence, poverty and helplessness and, in the longer run, to significantly reduce the prevalence of all forms of violence, including collective violence.[11]

104. All forms of violence are harmful and detrimental to the health and development of human beings, starting from the youngest children. Early childhood adversities, including all forms of violence against children, such as physical and emotional abuse and chronic neglect, if they are not timely addressed by healthy public policies, can result in chronic diseases in the adult affecting both physical and mental health.

105. The human rights approach, together with the modern understanding of public health, warns against typifying violence into severe forms and those forms which are considered to be "milder" and thus perceived as not harmful. That can lead to the proliferation of practices which are justified as being "mild" forms of violence and thus tolerated or even recommended, such as domestic violence against women, female genital mutilation or the institutional care of young children.

106. From the public health perspective, the cumulative effect of a large number of "mild cases" generates a heavier burden for the health of population than a smaller number of

[9] United Nations High Commissioner for Human Rights, opening speech to the high-level segment of the twenty-eighth session of the Human Rights Council, 2 March 2015.

[10] World Health Assembly resolution 49.25 (1996).

[11] See Etienne G. Krug et al. (eds.), "World report on health and violence" (WHO, Geneva, 2002). Available from www.who.int/violence_injury_prevention/violence/world_report/en/.

"severe cases".[12] The practice of tolerating and justifying milder forms of violence can pave the way to severe violations of human rights, which can amount to grave violations and even atrocities.

107. Any form of violence, including collective violence, does not originate in a vacuum. Violence has roots in unhealthy relationships amongst individuals, and is reinforced by the failure to promote and protect good-quality human relations, starting with relationships between an infant and the primary caregiver. The cycle of violence is reinforced when children grow up — whether in families or in institutions — without having their basic needs satisfied, which include not only the need to survive, but the need to feel secure and thus to enjoy the right to healthy development.

108. The most powerful way of preventing the epidemics of violence and different forms of insecurity in the modern world is the provision of holistic support to all forms of family unit, including access to food, shelter, health care and education, but also the provision of basic parenting skills. The quality of relationships between individuals in society is an increasingly important element in the realization of the right to health and the prevention of the cycle of violence. The right to a healthy environment should include not only the physical environment, but also the emotional and psychosocial environment in all settings, family units, schools, workplace, communities and societies at large.

109. The resilience and the protective factors in individuals, families communities and societies need to be promoted, and more investment in healthy human relationships, emotional and social well-being and social capital is required. The empowerment of all stakeholders — without exception — is an effective way of addressing major public health threats and violations of human rights, including the right to health.

G. The role of stakeholders

110. The Special Rapporteur considers the active and informed participation of all stakeholders to be one of the key elements of the analytical framework of the right to health. There is growing understanding and evidence that top-down relations between governments and local authorities and populations, including civil society, and paternalistic relations between health personnel and users of health-care services do not effectively contribute to the realization of the right to health.

111. The meaningful involvement of all actors and the empowerment of those who make use of services, especially the poor and other groups in vulnerable situations, is a crucial precondition for the full realization of the enjoyment by everyone of the right to health and other rights.

112. Civil society actors should be able to do their work for the promotion and protection of human rights, including the right to health, in safe and enabling environments and should not suffer from criminalization, stigmatization or harassment of any sort because of the work that they do (see the report of the Special Rapporteur on the situation of human rights defenders, A/HRC/25/55). The Special Rapporteur believes that there is a clear and direct link between the environment in which civil society operates in a given country and the level of realization of basic rights and freedoms, not only of the public freedoms that are necessary to advocating for human rights, but also of the specific rights for which they advocate. If civil society actors are harassed or persecuted due to their work advocating for

[12] See Geoffrey Rose, "A large number of people exposed to al small risk may generate many more cases than a small number exposed to a high risk", in *The Strategy of Preventive Medicine* (Oxford University Press, 1992).

and promoting the right to health, that is a symptom of important gaps in the realization of the right itself.

113. It is crucial to strengthen the trust and cooperation between public institutions and those representing the State and civil society actors representing the general public, including the most disadvantaged groups of society. The importance thereof should not be underestimated. Civil society plays a key role as agent of change, advocates good practices, provides independent monitoring and, in many instances, provides necessary services. Trustful partnerships between government agencies, State-run health-care services and the non-profit sector, including civil society, constitute one of the cornerstones of effective health systems and act as a guarantee for the effective realization of health-related human rights.

114. The role of medical doctors and other health-care professionals is also crucial. With the ongoing change of paradigm, from paternalistic top-down medicine to partnership between health-care providers and users, the medical profession should reconsider some of its traditional views. Health-care professionals need to strengthen effective self-regulatory practices and capacity-building activities within their professions so as to promote the best traditions of medicine and prevent ethical misconduct and human rights violations.

115. Education in the health-care sector is one important element in that regard. The doctrine of the "five star doctor"[13] needs to be reaffirmed in the light of translating modern values and scientific evidence into everyday medical practice. Modern medical doctors need to be not only good clinicians but also effective community leaders, communicators, decision makers and managers. That doctrine should be complemented by a strong human rights-based approach and evidence gained from the modern public health approach.

116. Strengthening the human rights dimension in health-care education curricula would be in the interests not only users of health services but also of medical doctors and other members of the health-care workforce. Medical education, as well as medical and health research, should help in providing tools to address imbalances when power asymmetries lead to too much focus on the tertiary level of health care, biomedical technologies and other components of the excessively exploited biomedical model.

117. The Edinburgh Declaration on medical education[14] should be recalled and education and research reoriented to the basics of social medicine through training in community settings and fostering social sciences and qualitative methods, which are as relevant as biomedical sciences and quantitative research. That would help in restoring the balance with a holistic approach to promoting the health and well-being of individuals and societies.

118. The role of private companies, such as pharmaceutical ones, should also be highlighted. The work of previous mandate holders has been crucial to underline their duties with regard to right to health, in particular the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines (A/63/263, annex). The Special Rapporteur will be addressing those issues with a view to ending unacceptable practices and entrenched misconceptions.

[13] Dr. Charles Boelen, "The five-star doctor. An asset to health care reform?" (WHO, Geneva). Available from www.who.int/hrh/en/HRDJ_1_1_02.pdf.

[14] See World Health Assembly resolution 42.39 (1989).

VI. Conclusions and observations

A. Conclusions

119. **Over the past few decades, measurable improvements have been made in health indicators and the realization of the right to health worldwide. This has enabled important progress in development goals, and the introduction in many countries of health-related public policies with a human rights and modern public health approach.**

120. **Moreover, the past 12 years have implied the consolidation of the framework of the right to health, based on the key role of human rights in policymaking. The Special Rapporteur hopes to continue contributing to the full realization of the right to health and related rights by providing guidance on how to address current challenges and how to exploit existing opportunities.**

121. **States have the primary responsibility to ensure a conducive environment for the full realization of the right to health, and related rights. But the role of other stakeholders is crucial in this respect.**

B. Observations

122. **In that connection, at the outset of his tenure, the Special Rapporteur would like to put forward the following observations:**

(a) Departure from universal human right principles and standards, as enshrined in the Universal Declaration of Human Rights, and from evidence provided by the modern public health approach is a major obstacle for effective realization of the right to health;

(b) History and evidence show that selective approaches to human rights reinforce the cycle of poverty, inequalities, social exclusion, discrimination and violence and are detrimental to the full enjoyment of the right to health;

(c) Inequalities and discrimination remain a crucial factor impeding the full realization of the right to health threatening the healthy development of individuals and societies;

(d) Unequivocal political will to apply human rights principles and standards to normative frameworks and public policies is key in addressing existing imbalances and power asymmetries in the formulation and implementation of health-related public policies;

(e) The meaningful participation and empowerment of all stakeholders should be promoted, in particular of groups in vulnerable situations, and effective monitoring and accountability mechanisms need to be in place to ensure the full realization of the right to health;

(f) The analysis of the functioning and financing of health-care systems, and the need to ensure the right to available, accessible, acceptable and good-quality health-care services remain crucial;

(g) The policy approach, if implemented effectively and creatively, opens up valuable opportunities for social innovations, through the empowerment of individuals, communities and societies at large;

(h) The role of health sector is becoming increasingly important, including for the promotion and protection of human rights, in particular of marginalized groups. The health sector should take the leadership in the promotion of "health in all policies" approach;

(i) Primary care needs to be strengthened as a crucial cornerstone of health system, enabling the effective use of discoveries of modern medicine and public health;

(j) Achieving universal health coverage is one of the main goals and processes for the post-2015 agenda; and commitments made in the Alma-Ata Declaration and Ottawa Charter for Health Promotion should be reaffirmed and revitalized by all stakeholders;

(k) There is no health without mental health. Good mental health means much more than the absence of mental impairment. Modern understanding of mental health includes good emotional and social well-being and healthy non-violent relations between individuals and groups with mutual trust, tolerance and respect of the dignity of every person;

(l) Mental health is relevant to many key elements of the post-2015 agenda and the formulation of the Sustainable Development Goals; and it should be a new priority in public policies addressed in parity with physical health;

(m) The effective promotion and protection of the rights of children and adolescents offers huge potential for the full realization of the right to health in our societies. Synergies between the right to survival and right to holistic development need to drive cross-sectoral policies and accountability mechanisms;

(n) The rights of persons with disabilities are of a special relevance to the right to health and should be protected and promoted through the lens of the Convention on the Rights of Persons with Disabilities. In that regard, the role of health-care services and professionals and the role of the biomedical model need to be reconsidered;

(o) Violence, as a public health problem, needs to be addressed with concerted efforts by all actors as a human rights challenge, having a detrimental impact on the health of individuals and societies. There should be no excuse or justification for any form of violence;

(p) Trustful partnerships between the policymakers responsible for the health sector and civil society actors, including non-governmental organizations, academia and professional associations, constitute one of the cornerstones of effective health systems, and act as a guarantee for the full realization of the right to health and related rights.